# POLICIES AND PROCEDURE MANUAL

| Chapter: | Utilization Management | | |
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| **Title:** | **Utilization Management** | | |
| **Policy:** ☒<br>**Procedure:**☐<br>**Version:** 5.0<br>**Page:** 1 of 7 | **Review Cycle:** Annually<br><br>**Author:**<br>UM Director and UM Committee | **Adopted Date: 11.22.2013**<br><br>**Review Date:** 01.09.2018<br><br>**Revision Eff. Date:** 11.2015 | **Related Policies:**<br>UM-Access<br>Service Philosophy |

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## Purpose

Mid-State Health Network (MSHN), either directly or through delegation of function to its provider network, is responsible for the region's Utilization Management (UM) system. Through contract, MSHN has identified the retained and delegated functions of the networks UM system. MSHN is responsible for oversight and monitoring of all UM functions.

UM is a set of administrative functions that assure appropriate clinical service delivery. In short, this means the "right service in the right amount to the right individuals from the right service provider". These functions occur through the consistent application of written policies and eligibility criteria

## Policy

MSHN UM functions are performed in accordance with approved MSHN policies, protocols and standards and may be delegated to its provider network or directly administered by the Pre-Paid Inpatient Health Plan (PIHP) (see Attachment A). This includes monitoring of local prospective, concurrent and retrospective reviews of authorization and UM decisions, activities regarding level of need and level/amount of services. MSHN maintains a Utilization Management Delegation Grid (see Attachment B) that defines whether a utilization management function is considered retained or delegated.

MSHN provider network shall have mechanisms to identify and correct under/over-utilization of services; as well as procedures for conducting prospective, concurrent, and retrospective reviews. Qualified health professionals shall supervise review decisions. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to provide treatment in consultation with the primary care physician as appropriate. MSHN conducts data-driven analysis of regional utilization patterns, and monitoring for over-and under-utilization across the region.

Principles:

Utilization management must be based on valid data in order to produce reliable reports required to analyze patterns of utilization, determine clinical effectiveness of the service delivery model and compare cost-effectiveness and outcomes of services.

- Value-based purchasing assures appropriate access, quality, and the efficient and economic provision of supports and services.
- The MSHN UM framework is not a mandate for clinical decision-making, but instead aims to define and standardize criteria, factors, and outcomes for evaluation purposes.

- The MSHN Utilization model will be consistent with MDHHS contract requirements, Balance Budget Act of 1997, and national accreditation standards
- National standards and metrics are utilized throughout the model wherever possible (standardized tools, recognized process metrics, and outcome measures)

Utilization Management Structure:
The UM Committee is the primary body responsible for evaluating the utilization of MSHN provider network services and making recommendations to the MSHN Chief Executive Officer (CEO), Chief Compliance Officer (CCO) and the Operations Council (OC). The UM Committee is responsible for reviewing aggregated and trend data related to the implementation and effectiveness of the UM plan.

- *Utilization Management Committee:* The UM Committee is comprised of the MSHN CEO, MSHN CCO, and the CMHSP Participants' Utilization Management staff appointed by the respective CMHSP Participant CEO/Executive Director (ED). All CMHSP Participants shall have equal representation on this committee. Retain and delegated UM functions are outlined in the MSHN Utilization Organization Chart.
- *Operations Council*: The Operations Council reviews reports concerning utilization and quality improvement matters as identified by the Quality Improvement Council (QIC) and UM Committee and makes recommendations for regional planning and improvement to the MSHN CEO. The Operations Council shall be comprised of the CEO/ED of each CMHSP Participant.

Utilization Management Plan:
MSHN shall create, implement and maintain a region-wide UMP that complies with applicable federal and state statutes, laws and regulations. The MSHN UMP shall adhere to regulations established by governing bodies including the Michigan Department Health & Human Services (MDHHS), Medicaid Services Administration, Centers for Medicaid and Medicare, and relevant accrediting bodies.

A. The MSHN UM Plan shall be implemented in a manner which remains true to MSHN Service Philosophies, particularly person/family centeredness, self-determination, cultural sensitivity, trauma informed/sensitive, and responsiveness to co-occurring (dual-diagnoses) conditions.
B. All CMHSP Participants/Provider Network shall create policies and procedures necessary to fulfill all aspects of the CMHSP UMP that include criteria for evaluating medical necessity and processes for reviewing and approving the provision of services.
C. MSHN will monitor CMHSP Participant/Provider Network follow-through, specifically evidence of local monitoring for over/under utilization, consistent and responsive to regionally identified patterns and trends.
D. All CMHSP Participants/ Provider Network shall establish procedures for prospective (preauthorization), concurrent, and retrospective authorizations. Procedures shall ensure that:
    1. Review decisions that deny or reduce services are supervised by qualified professionals who have appropriate clinical expertise.
    2. Efforts are engaged to obtain all necessary information, including pertinent clinical data and consultation with the treating physician or prescriber as appropriate for decision making.
    3. Reasons for decisions are clearly documented and readily available to service recipients.
    4. Appeals mechanisms for both providers and service recipients are well-publicized and readily-available. Notification of denial decisions shall include a description of how to file an appeal, and shall be provided to both the beneficiary and the provider.
    5. Decisions and appeals are conducted in a timely manner as required by the exigencies of the situation.
    6. Mechanisms are implemented to evaluate the effects of the program using data related to consumer satisfaction, provider satisfaction, or other appropriate measures.

Authorization for Treatment & Support Services:
Initial and ongoing approval or denial of requested services is delegated to the local CMHSP Participants. This approval or denial includes the screening and authorization of psychiatric inpatient services, partial hospitalization, and initial and ongoing authorization of services for individuals receiving community mental health services. Communication with individuals regarding UM decisions, including adequate and advance notice, right to second opinion, and grievance and appeals shall be provided in accordance with the Medicaid Managed Specialty Supports and Services contract with the MDHHS. The reasons for treatment decisions shall be clearly documented and available to Medicaid beneficiaries. Information regarding all available appeals processes and assistance through customer services is communicated to the consumer. MSHN shall monitor affiliate authorization, second opinions and appeals processes to ensure compliance with PIHP, State and Federal requirements.

1. Utilization reviews are conducted using medical necessity criteria adopted or developed specifically to guide the level of care and appropriate care planning (Medicaid Provider Manual). This may include, but is not limited to, appropriate length of stay for each level of care according to identified needs of the beneficiary in order for payment to be authorized.

2. The responsibility for managing the utilization of clinical care resources is delegated to the MSHN provider network/professional staff members who assess the needs of and authorize care for beneficiaries receiving services funded by the PIHP.

3. Decisions regarding the type, scope, duration and intensity of services to authorize or deny must be:
    a. Accurate and consistent with medical necessity criteria;
    b. Consistent with Medicaid eligibility, entry, continuing stays and discharge criteria as applicable;
    c. Consistent with formal assessments of need and beneficiary desired outcomes;
    d. Consistent with established guidelines (Medicaid Provider Manual);
    e. Adjusted appropriately as beneficiary needs, status, and/or service requests change;
    f. Timely;
    g. Provided to the consumer in writing as to the specific nature of the decision and its reasons;
    h. As applicable, shared with affected service providers verbally or in writing as to the specific nature of the decision and its reasons if there are any concerns with decisions made;
    i. clearly documented as to the specific nature of the services authorized or denied and the reasons for denial; and
    j. Accompanied by the appropriate notice to consumers regarding their appeal rights with a copy of the notice placed in the consumer's clinical case record.

4. Additional mental health services (through authority of 1915(b)(3) of the Social Security Act ("B3" services) are intended to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. Authorization and use of Medicaid funds for any B3 supports and services (including amount, scope, and duration) are dependent upon:
    a. The Medicaid beneficiary's eligibility for specialty services and supports;
    b. Services have been identified during person-centered planning;
    c. Services are medically necessary;
    d. Services are expected to achieve one or more of the goals listed in 4;

e. Decision to authorize B3 services (including amount scope and duration) must take into account MSHN's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services.

5. MSHN CMHSP Participants shall not deny the use of a covered service based on preset limits of units or duration; but instead reviews the continued medical necessity on an individualized basis.

6. MSHN assures that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

Outlier Management:
Consistent with Balanced Budget Act (BBA) requirements addressed in Title 42 -Public Health, Part 438.240 (Quality Assessment and Performance Improvement Program), MSHN is responsible to ensure that all Provider Network Members have in effect mechanisms to detect both under-utilization and over-utilization of services. The intent of the outlier management approach is to identify under-utilization or over-utilization and explore and resolve it collaboratively with involved CMHSP Participants.
Oversight and Monitoring:
Annually MSHN and the UM Committee shall conduct a review of this plan and its stated priorities for action (Attachment B) to assure program effectiveness. MSHN's Medical Director shall be involved in the review and oversight of access system policies and clinical practices.

Additionally, MSHN shall provide oversight and monitoring to ensure that the CMHSP participants meet the following standards:

1. CMHSP participants shall ensure that the access system staff are qualified, credentialed and trained consistent with the Medicaid Provider Manual, the Michigan Mental Health Code and the MDHHS/PIHP contract.
2. CMHSP participants shall ensure that there is no conflict of interest between the coverage determination and the access to, or authorization of, services.
3. CMHSP participants shall monitor provider capacity to accept new individuals, and be aware of any providers not accepting referrals at any point in time.
4. CMHSP participants shall routinely measure telephone answering rates, call abandonment rates and timeliness of appointment and referrals at any point in time. Any performance issues shall be addressed through the PIHP Quality Assurance and Process Improvement Plan.
5. CMHSP participants shall assure that the access system maintains medical records in compliance with state and federal standards.
6. The CMHSP participants shall work with individuals, families, local communities, and others to address barriers to using the access system, including those caused by lack of transportation.

**Applies to:**
☒ All Mid-State Health Network Staff
☐ Selected MSHN Staff, as follows:
☒ MSHN's Affiliates: ☐ Policy Only ☒ Policy and Procedure
☒ Other: Sub-contract Providers

**Definitions/Acronyms:**
CMHSP: Community Mental Health Service Program (inclusive of substance Use Service Provision, coordination and administrative oversight)
Contractual Provider: refers to an individual or organization under contract with MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP Participants who hold retained functions contracts.
Employee: refers to an individual who is employed by the MSHN PIHP. MDHHS: Michigan Department of Health & Human Services
MSHN: Mid-State Health Network PIHP: Prepaid Inpatient Health Plan
Subcontractors: refers to an individual or organization that is directly under contract with CMHSP and/or MSHN to provide behavioral health services and/or supports.
Provider Network: refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements.
Staff: refers to an individual directly employed and/or contracted with a CMHSP Participant or SUD providers.
SUD: Substance Use Disorder
UM: Utilization Management
UMC: Utilization Management Committee

**Related Materials:**
MSHN Utilization Management Plan

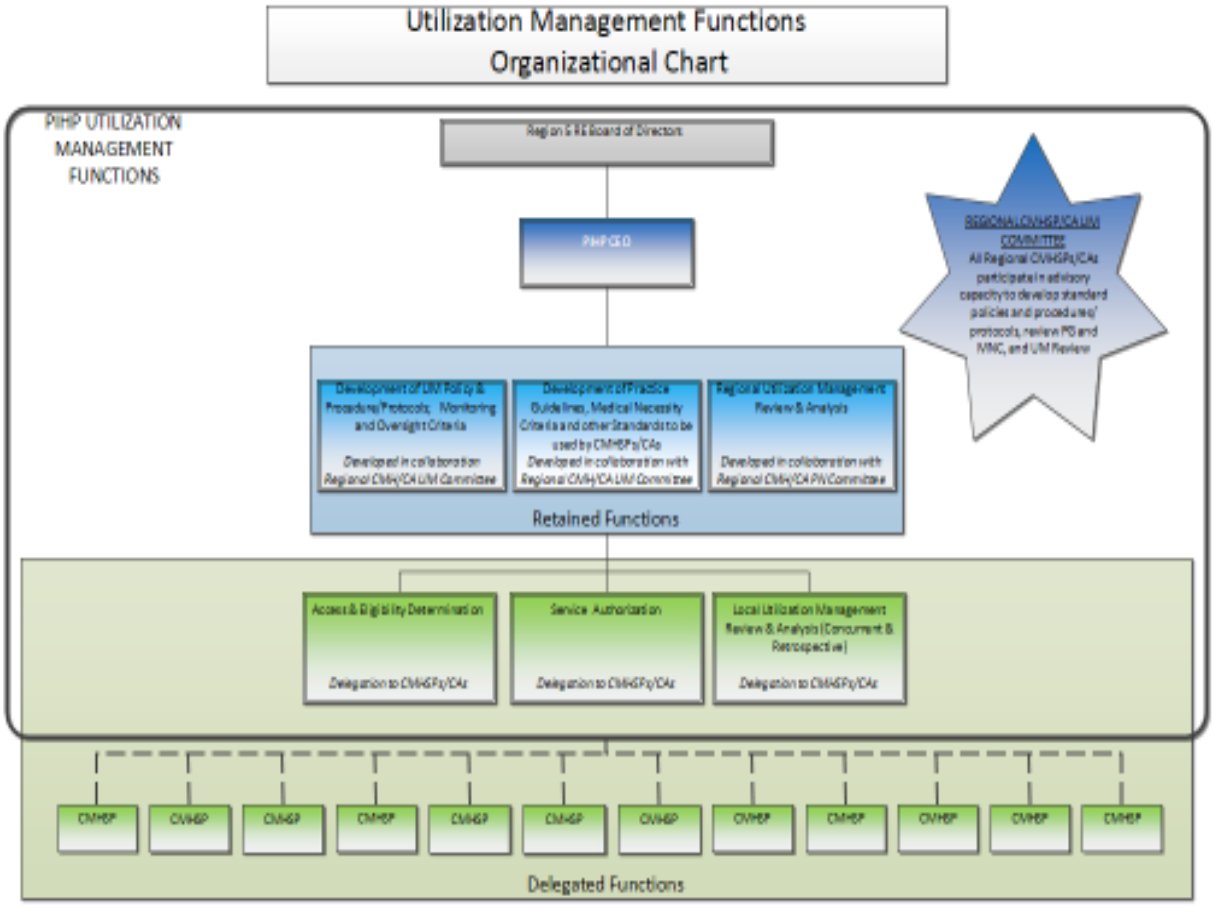
**References/Legal Authority:**
1. MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P.6.3.2.1: The Appeal and Grievance Resolution Processes Technical Requirement, July 2004.
2. MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P.7.1.1: Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans, Current Year
3. MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P.6.5.1.1: Michigan Mission-Based Performance Indicator System, Version 6.0 for PIHPs
4. MDHHS Medicaid Providers Manual, 4/1/2013 (current edition).
5. MSA Bulletin: Mental Health/Substance Abuse 04-03 (Prepaid Inpatient Health Plans)
6. 42 CFR 438.404c(5)(6)

**Change Log:**

| Date of Change | Description of Change | Responsible Party |
|---|---|---|
| 11.23.2013 | New MSHN policy | L. Verdeveld |
| 03.14.2014 | Alignment with service philosophy and addition of "prescriber." | Dr. H. Lenhart |
| 04.09.2014 | To reflect input of the Utilization Management and Substance Use Disorder Committee/Workgroup | D. McAllister |
| 07.23.2015 | UM Committee feedback on MSHN monitoring of over/under utilization; and B3 service clarification of reasonable and equitable, clarify FY15 contract provisions. | UMC |
| 04.25.2016 | Moved description of UM delegation grid to UM Policy. | UMC |
| 10.27.2016 | Annual review by UMC-no changes. | UMC |
| 10.26.2017 | Annual review by UMC-no changes. | UMC |

## Attachment A

### MSHN Utilization Management Functions Organization Chart



## Attachment B

# MSHN Utilization Management Delegation Grid

| **PIHP Delegated Activity** | Retained or delegated? | If retained: Conducted internally by MSHN or contracted? |
|---|---|---|
| Initial approval or denial of requested service:<br>- Initial assessment for and authorization of psychiatric inpatient services;<br>- Initial assessment for and authorization of psychiatric partial hospitalization services;<br>- Initial and ongoing authorization of services to individuals receiving community-based services;<br>- Grievance and Appeals, Second Opinion management, coordination and notification;<br>- Communication with consumers regarding UM decisions, including adequate and advanced notice, right to second opinion and grievance and appeal | ___ Retained by MSHN<br><br>☑ Delegated to local CMHs<br><br>*This topic has been marked as an implementation issue requiring the development of a specific policy or procedure at the MSHN level. | ☐Conducted by MSHN<br>☐Contracted |
| Local-level Concurrent and Retrospective Reviews of affiliate Authorization and Utilization Management decisions/activities to internally monitor authorization decisions and congruencies regarding level of need with level of service, consistent with PIHP policy, standards and protocols. | ___ Retained by MSHN<br><br>☑ Delegated to local CMHs | ☐Conducted by MSHN<br><br>☐Contracted |
| Persons who are enrolled on a habilitation supports waiver must be certified as current enrollees and be re-certified annually. A copy of the certification form must be in the individual's file and signed by the local CMHSP representative. | *This will be a **local responsibility** that is **prompted centrally by MSHN**. It will be a central responsibility to manage the resource of waiver slots and provide oversight. | ☒Conducted by MSHN<br><br>☐ Contracted |
| Development, adoption and dissemination of Practice Guidelines (PGs), Medical Necessity Criteria, and other Standards to be used by the local CMHSP. 42 CFR: 438.236: Practice Guidelines | ☑ Retained by MSHN<br><br>___Delegated to local CMHs | ☒Conducted by MSHN<br><br>☐Contracted |
| Development, modification and monitoring of related PIHP UM Policy, Procedures and Annual Plan as part of the Affiliation QI Plan. | ☑ Retained by MSHN<br><br>___Delegated to local CMHs | ☒Conducted by MSHN<br><br>☐Contracted |
| Review and Analysis of the CMHSP's quarterly utilization activity and reporting of services. Annual review of each CMHSP's and the PIHP's overall Utilization Activities. | ☑ Retained by MSHN<br><br>___Delegated to local CMHs | ☒Conducted by MSHN<br><br>☐Contracted |